340B Drug Pricing Program: Hospital Registration Instructions

In order to be registered on the 340B database, there are TWO required steps that must be taken on the same day within one of the four open registration periods each year. Registrations submitted without the required documents will be deleted without being reviewed.

1. COMPLETE ONLINE REGISTRATION FORM

Hospitals must submit an online registration form. Registrations must be signed and submitted electronically by the Authorizing Official. The Authorizing Official must be a senior managing official that has the authority to bind the organization with the federal government (such as the CEO, CFO, COO, Executive Director, President, Vice President or similar). The primary contact must be an employee of the covered entity (consultants and other third parties may not be listed as the primary contact).

2. SUBMIT SUPPORTING DOCUMENTATION

The hospital must submit the following supporting documentation as outlined below to the appropriate email address listed at the bottom of this page.

DOCUMENTS REQUIRED FOR A SUCCESSFUL REGISTRATION

From the hospital's most recently filed Medicare cost report:

- ☐ Worksheet S, signed and dated
- ☐ Worksheet S-2
- ☐ Worksheet S-3 (children's hospitals only)
- ☐ Worksheet E, Part A (does not apply to critical access or children's hospitals)

For outpatient facility registrations, also submit:

- ☐ Worksheet A - highlight the cost center line(s) that reflect the clinic(s) being registered
- ☐ Worksheet C - highlight the cost center line(s) that reflect the clinic(s) being registered
- ☐ Working trial balance - highlight the clinic(s) being registered, as shown in the example]

Depending on the hospital's classification type, one of the following:

- ☐ Certification of Ownership/Operation by a Unit of State/Local Government
- ☐ Certification of Contract Between Private, Non-Profit Hospital And State/Local Government
- ☐ Public or Private Non-Profit Hospital that has been formally granted governmental powers must provide the following:
  - The identity of the government entity granting the governmental power to the hospital;
  - A description of the governmental power that has been granted to the hospital and a brief explanation as to why the power is considered to be governmental; and
  - A copy of an official document issued by the government to the hospital that reflects the formal granting of governmental power.
  - Hospitals reporting eligibility via a government contract or grant of governmental powers must also provide verification of non-profit status, such as articles of incorporation or IRS recognition of tax exemption.

TO AVOID DELAYS IN YOUR REGISTRATION

OPA has established specific e-mail addresses and fax numbers for each registration type; please e-mail or fax materials to the appropriate address or number for your hospital. Hospitals **MUST** include their Medicare provider number in the subject line of the e-mail or prominently on the fax cover sheet.

Registration Type	E-mail address	Fax
Disproportionate Share Hospitals	340BRegistrationDSH@hrsa.gov	301-443-6571
Critical Access Hospitals	340BRegistrationCAH@hrsa.gov	301-443-6572
Sole Community Hospitals	340BRegistrationSCH@hrsa.gov	301-443-6573
Rural Referral Centers	340BRegistrationRRC@hrsa.gov	301-443-6574
Freestanding Cancer Hospitals	340BRegistrationCAN@hrsa.gov	301-443-6575
Pediatric Hospitals	340BRegistrationPED@hrsa.gov	301-443-6576

OPA does not require original signed documents, but registrants may utilize courier services in lieu of e-mail or fax:

Office of Pharmacy Affairs
Health Resources and Services Administration
Mail Stop 8W03A
5600 Fishers Lane
Rockville, MD 20857

For additional information regarding eligibility requirements, as well as an overview of our eligibility review process, please refer to the Office of Pharmacy Affairs (OPA) website at http://www.hrsa.gov/opa/index.html.

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN:	*PERIOD* *FROM* _____ *TO* _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: Time:
2. [ ] Manually submitted cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report
4 [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [ ] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received:_____
7. Contractor No.:_____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date:_____
11. Contractor's Vendor Code: _____
12. [ ] If line *5*, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by_____{Provider Name(s) and Number(s)}for the cost reporting period beginning_____and ending_____and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, *and that the services* identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL						200

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:			1
2	City:	State:	Zip Code:	County:	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital									3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, *CORF and OPT*)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From:	To:	20
21	Type of control (see instructions)			21

	Inpatient PPS Information	1	2	
22	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.06 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.			22
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.			23

		In-State Medicaid paid days	In-State Medicaid eligible *unpaid* days	Out-of State Medicaid paid days	Out-of State Medicaid eligible *unpaid* days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	*If this provider is an IPPS hospital*, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible *unpaid* days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible *unpaid* days in col. 4, Medicaid HMO *paid and eligible but unpaid* days in col. 5, and other Medicaid days in col. 6.							24
25	*If this provider is an IRF*, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible *unpaid* days in col. 2, out-of-state Medicaid paid days in col. 3, out-of state Medicaid eligible *unpaid* days in col. 4 Medicaid HMO *paid and eligible but unpaid* days in col. 5 and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.			26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. *Enter in column 1*, "1" for urban or "2" for rural. *If applicable enter the effective date of the geographic reclassification in column 2.*			27

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures								1
2	00200	Capital Related Costs-Movable Equipment								2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits								4
5	00500	Administrative and General								5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service								8
9	00900	Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42	04200	Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)								118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)				- 0 -				200

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)												30
31	Intensive Care Unit												31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41
42	Subprovider (Specify)												42
43	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
	ANCILLARY SERVICE COST CENTERS												
50	Operating Room												50
51	Recovery Room												51
52	Labor Room and Delivery Room												52
53	Anesthesiology												53
54	Radiology-Diagnostic												54
55	Radiology-Therapeutic												55
56	Radioisotope												56
57	Computed Tomography (CT) Scan												57
58	Magnetic Resonance Imaging (MRI)												58
59	Cardiac Catheterization												59
60	Laboratory												60
61	PBP Clinical Laboratory Services-Prgm. Only												61
62	Whole Blood & Packed Red Blood Cells												62
63	Blood Storing, Processing, & Trans.												63
64	Intravenous Therapy												64
65	Respiratory Therapy												65
66	Physical Therapy												66
67	Occupational Therapy												67
68	Speech Pathology												68

COMPUTATION OF RATIO OF COSTS TO CHARGES

PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
69	Electrocardiology												69
70	Electroencephalography												70
71	Medical Supplies Charged to Patients												71
72	Implantable Devices Charged to Patients												72
73	Drugs Charged to Patients												73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
	OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic												90
91	Emergency												91
92	Observation Beds (see instructions)												92
93	Other Outpatient Service (specify)												93
	OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis												94
95	Ambulance Services												95
96	Durable Medical Equipment-Rented												96
97	Durable Medical Equipment-Sold												97
98	Other Reimbursable (specify)												98
99	Outpatient Rehabilitation Provider (specify)												99
100	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
	SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
200	Subtotal (see instructions)												200
201	Less Observation Beds												201
202	Total (see instructions)												202

OPA Hospital - Provider CCN: 123456
FY2011 Trial Balance 1/1/2011-12/31/11

Cost Center ID	Cost Center Name	CR Line	Salary Expenses	Non-Salary Expenses	Total Expenses	Inpatient Rev.	Medical Supplies	Implantable Devices	Total Inpt. Rev. (Worksheet C)	Outpatient Rev.	Medical Supplies	Implantable Devices	Total Outpt. Rev. (Worksheet C)	Total Pat Revenue (Worksheet C)
34000810	Benefits	4	$ 889,819.00	$ 55,077,929.00	$ 55,967,748.00	$ -			$ -	$ -	$ -	$ -	$ -	$ -
34001000	Human Resources	4	$ -	$ 115,787.00	$ 115,787.00	$ -			$ -	$ -	$ -	$ -	$ -	$ -
34002250	Employee Health	4	$ 276,662.00	$ 181,322.00	$ 457,984.00	$ -			$ -	$ -	$ -	$ -	$ -	$ -
34005052	Fitness Center	4	$ 309,142.00	$ 53,820.00	$ 362,962.00	$ -			$ -	$ -	$ -	$ -	$ -	$ -
		total	$ 1,475,623.00	$ 55,428,858.00	$ 56,904,481.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
34003862	Bariatric Center	50	$ 54,270.00	$ 443,317.00	$ 497,587.00	$ -			$ -	$ -	$ -	$ -	$ -	$ -
34005630	XYZ Surgery Center	50	$ 2,974,018.00	$ 2,818,273.00	$ 5,792,291.00	$ 1,245,807.00	$ (126,191.81)	$ (109,985.69)	$ 1,009,629.50	$ 45,650,576.00	$ (6,163,084.11)	$ (4,108,849.75)	$ 35,378,642.14	$ 36,388,271.64
34005810	Operating Room	50	$ 3,410,534.00	$ 20,445,328.00	$ 23,855,862.00	$ 11,643,362.00	$ (26,236,137.79)	$ (31,669,868.17)	$ (46,262,643.96)	$ 41,630,849.00	$ (5,845,584.62)	$ (10,002,040.18)	$ 25,783,224.20	$ (20,479,419.76)
		total	$ 6,438,822.00	$ 23,706,918.00	$ 30,145,740.00	$ 12,889,169.00	$ (26,362,329.60)	$ (31,779,853.86)	$ (45,253,014.46)	$ 87,281,425.00	$ (12,008,668.73)	$ (14,110,889.93)	$ 61,161,866.34	$ 15,908,851.88
34006101	CAT Scan-Radiology	54	$ 902,805.00	$ 577,411.00	$ 1,480,216.00	$ 12,567,655.00			$ 12,567,655.00	$ 25,393,530.00			$ 25,393,530.00	$ 37,961,185.00
34006102	MRI	54	$ 569,715.00	$ 698,048.00	$ 1,267,763.00	$ 3,714,711.00			$ 3,714,711.00	$ 18,007,177.00	$ (69.80)		$ 18,007,107.20	$ 21,721,818.20
34006103	Nuclear Medicine	54	$ 375,289.00	$ 482,393.00	$ 857,682.00	$ 1,020,049.00			$ 1,020,049.00	$ 4,821,486.00			$ 4,821,486.00	$ 5,841,535.00
34006104	Ultrasound	54	$ 989,840.00	$ 216,159.00	$ 1,205,999.00	$ 3,721,113.00	$ (602.00)		$ 3,720,511.00	$ 8,013,086.00			$ 8,013,086.00	$ 11,733,597.00
34006106	General Radiology	54	$ 1,341,538.00	$ 378,286.00	$ 1,719,824.00	$ 12,571,216.00			$ 12,571,216.00	$ 7,552,452.00	$ (30.20)		$ 7,552,421.80	$ 20,123,637.80
34006108	OR Diagnostics MRI	54	$ 90,161.00	$ 19,937.00	$ 110,098.00	$ 2,247,389.00			$ 2,247,389.00	$ 2,146,320.00			$ 2,146,320.00	$ 4,393,709.00
34006113	CT/MRI II	54	$ 181,048.00	$ 1,247,411.00	$ 1,428,459.00	$ 348,554.00			$ 348,554.00	$ 4,005,929.00			$ 4,005,929.00	$ 4,354,483.00
34006114	Interventional Radiology	54	$ 1,226,014.00	$ 3,136,945.00	$ 4,362,959.00	$ 5,147,762.00	$ (3,288.40)	$ (54,160.20)	$ 5,090,313.40	$ 33,096,848.00	$ (213.60)		$ 33,096,634.40	$ 38,186,947.80
34006122	Imaging Supplies Tracking	54	$ -	$ -	$ -	$ 8,898,335.00	$ (4,088,050.36)	$ (3,841,973.80)	$ 968,310.84	$ 5,642,207.00	$ (3,505,383.18)	$ (1,329,602.40)	$ 807,221.42	$ 1,775,532.26
34006133	PET	54	$ -	$ 17,631.00	$ 17,631.00	$ 59,738.00			$ 59,738.00	$ -			$ -	$ 59,738.00
		total	$ 5,676,410.00	$ 6,774,221.00	$ 12,450,631.00	$ 50,296,522.00	$ (4,091,940.76)	$ (3,896,134.00)	$ 42,308,447.24	$ 108,679,035.00	$ (3,505,696.78)	$ (1,329,602.40)	$ 103,843,735.82	$ 146,152,183.06
34005300	Respiratory Therapy	65	$ 789,286.00	$ 338,079.00	$ 1,127,365.00	$ 16,489,357.00	$ (70,464.00)		$ 16,418,893.00	$ 2,444,033.00	$ (3,785.60)		$ 2,440,247.40	$ 18,859,140.40
34005310	Pulmonary Function	65	$ 75,744.00	$ 29,283.00	$ 105,027.00	$ 112,803.00			$ 112,803.00	$ 425,937.00			$ 425,937.00	$ 538,740.00
		total	$ 865,030.00	$ 367,362.00	$ 1,232,392.00	$ 16,602,160.00	$ (70,464.00)	$ -	$ 16,531,696.00	$ 2,869,970.00	$ (3,785.60)	$ -	$ 2,866,184.40	$ 19,397,880.40
34005006	Cardiovascular Lab	69	$ 8,186,830.00	$ 12,257,758.00	$ 20,444,588.00	$ 65,998,878.00	$ (11,813,832.30)	$ (22,402,339.20)	$ 31,782,706.50	$ 36,931,683.00	$ (5,248,724.50)	$ (12,808,002.50)	$ 18,874,956.00	$ 50,657,662.50
34005020	Heart Center Admin	69	$ 1,325,940.00	$ 67,266.00	$ 1,393,206.00	$ -			$ -	$ -			$ -	$ -
34005032	Same Day Interventional	69	$ 755,480.00	$ 143,933.00	$ 899,413.00	$ 508,666.00	$ (236.60)		$ 508,429.40	$ 21,696,273.00	$ (1,419.60)		$ 21,694,853.40	$ 22,203,282.80
34005036	Non-Invasive Cardio	69	$ 2,349,816.00	$ 2,550,244.00	$ 4,900,060.00	$ 12,144,440.00			$ 12,144,440.00	$ 32,427,044.00	$ (2,765.20)		$ 32,424,278.80	$ 44,568,718.80
34005054	Vascular Center	69	$ 920.00	$ 124.00	$ 1,044.00	$ -			$ -	$ 5,817.00			$ 5,817.00	$ 5,817.00
		total	$ 12,618,986.00	$ 15,019,325.00	$ 27,638,311.00	$ 78,651,984.00	$ (11,814,068.90)	$ (22,402,339.20)	$ 44,435,575.90	$ 91,060,817.00	$ (5,252,909.30)	$ (12,808,002.50)	$ 72,999,905.20	$ 117,435,481.10
34009922	XYZ Clinic	91.09	$ 404,900.00	$ 269,404.00	$ 674,304.00	$ 25,446.00			$ 25,446.00	$ 3,982,723.00	$ (728.80)		$ 3,981,994.20	$ 4,007,440.20
34009923	XYZ Physicians	91.09	$ 510,193.00	$ 69,055.00	$ 579,248.00	$ -			$ -	$ 1,382,005.00			$ 1,382,005.00	$ 1,382,005.00
		total	$ 915,093.00	$ 338,459.00	$ 1,253,552.00	$ 25,446.00	$ -	$ -	$ 25,446.00	$ 5,364,728.00	$ (728.80)	$ -	$ 5,363,999.20	$ 5,389,445.20